## State of Utah

**Public Employees Health Program** 560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004 Customer Service: 801-366-7555 / Toll Free 800-765-7347

Group Term Life Enrollment and Change Form

Section A

Employee Information							
☐ New Enrollment ☐ Status Change (Ple	ease specify type):						
EMPLOYEE NAME (last, first, middle initial)	SOCIAL S	ECURITY N	IUMBER	BIRTH DATE	(mm/dd/yy)	MARITAL STATUS	GENDER Male
HOME ADDRESS	CITY / STA	ATE / ZIP				Marrie	d Female
						WORK PHO	NE
EMPLOYER / DEPARTMENT				HIRE DATE (	mm/dd/yy)	HOME PHON	NE
Did you transfer from another Agency/Department?	No If Yes, which	h Agency	/Departme	nt?			
Section B		_					
Coverage Information							
Select the desired coverage the primary and secondary dependent coverage, the beamounts are reduced at agbenefits, the maximum coverage.	v beneficiaries for Employ peneficiary for each insur ge 66, see Benefit Bookle	vee & Spo ed depen et for deta	ouse Term i dent is auto	Life Covera omatically	ag e. If you of the insured	elect to enro employee. C	ll in Coverage
	EMPLOYEE 1	TERM LII	E				
Minimum Group Term Life Coverage - funded by your employer for all eligible em		erage for	employees	up to age	66. Minimui	n Group Tei	rm Life is
Basic Group Term-Life Coverage - Pro employer paid Minimum of \$18,000 for a to please complete the Health Statement.							
Additional Group Term-Life Coverage - To complete the Employee Health Statement. Th						sic Term -Lif	e and
Select the amount of Additional Term Life Cov		\$100	_	\$150,00		00,000	\$250,000
	SPOUSE TE	RM LIFE					
Select the amount of Spouse Coverage:  If applying within 60 days of hire for 15,000 or	\$5,000 \$15,000 less a health statement			000 🗌 \$90 rwise com		,	\$150,000 Statement.
SPOUSE NAME (last, first, middle initial)	BIRTH DATE (mm/dd/yy)			MARRIAG	E DATE (mm/do	l/yy/)	
	DEPENDENT CHI	LD TERM	/ LIFE				
Dependent Group Term Life Coverage is for u			Coverage F	Per Child*	<u>\$5,000</u>	\$7,500 [	\$10,000
You must be enrolled in Basic or Minimum Grundent Child Term Life. Premium covers A Health Statement is required for each dependent, or event.	all eligible dependent chi	ildren.	Bi-Weekly *Coverage to age 6 m	amount is	.30 limited to \$1	.45 ,000 for nev	.60 wborn's up
Enter the number of eligible dependents to en	ıroll:		J				
		FOR PEHP U	SE ONLY				
Signature required, see Section D.		Effective I	Date:		ficate No.:		mum:
		Basic:		Additiona	11.	Depende	III.

Verified By:

Date:

Employee Name:

## **Group Term Life Beneficiary Designation**

Social Security Number:

	Section	C - Beneficiary Design	ation		
		Please enter the beneficial Term Life Coverage). The	ries for the Employ beneficiary for Dep	ee coverage a pendent Child	and Spouse coverage (i f you have applied for Spouse Term Life coverage is automatically the insured employee.
		beneficiary, if the primary beneficiary is	peneficiary is decea listed, the benefit w	ased benefits vill be divided	ondary (death benefi ts are first paid to the primary would be paid to t he secondary beneficiary). If more than equally among th ose listed, unless otherwise instructed on vill be paid to you r estate, as provided for by the plan.
(Che	ck One)		EMPLOYEE TER	M LIFE BEN	EFICIARIES
Primary	Secondary	BENEFICIARY NAME (Last, First, Middle Initial)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE	MAILING ADDRESS (Address / City / State / Zip)
(Che	ck One)		SPOUSE TERM	I LIFE BENE	
Primary	Secondary	BENEFICIARY NAME (Last, First, Middle Initial)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE	MAILING ADDRESS (Address / City / State / Zip)
5	Section D				
	Emplo	yee Agreement & Sig	gnature		

Group Term Life Master Policy.

EMPLOYEE SIGNATURE

DATE

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term-Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP

#### State of Utah

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004 **Group Term Life** Enrollment: 801-366-7555 / Toll Free 800-753-7437 **Employee Health Statement** 

E	mployee Name:				S	Socia	l Securi	ty Nu	mber:			_
 [;	Section A											
L	Employee Hea	olth Statement										
			ourself. Th	is informa	ation is	requi	red if app	lying fo	r Additi	ional Term Life Coverage or	if apply	ing for
	Basic Teri	m Life Coverage after 60	days fron	n hire.								
Emp	loyee Height (Ft., In.):	Em	ployee W	eight:				Оссира	tion:			
1 Have	you ever had symptom	s, been diagnosed with,	or heen tr	eated for	1 Ha	VA VOI	ı had or o	currentl	v have	any known physical		
1.11440	a. High blood pressure	o, been diagnosed with,	Yes	No						mpairments, disorders or ill	Yes	□No
	b. Seizures or convulsion	ons	Yes	☐ No	healtl	h not r	nentioned	d in que	estion #	1?		
	c. Mental or nervous co		Yes	☐ No	5. Ha	ve you	ı ever be	en den	ied life	or health insurance	□ Vaa	□ No
	d. Lung or respiratory d		Yes	☐ No	cover	ragé, c	or receive	d an in	crease	d premium rating for health	☐ Yes	☐ No
	e. Digestive or rectal di		Yes	□ No	6. Ha	ve voi	u had an	electro	cardiog	ram, x-ray, laboratory		
	f. Blood or blood vesse		Yes	☐ No	study	, bloo	d study, b	ody sc		agnostic procedure within	☐ Yes	☐ No
	<ul><li>g. Urinary tract disorder</li><li>h. Skeletal, spine, joint</li></ul>		Yes	☐ No	the p	ast thr	ee years'	?				
	I. Thyroid, breast or oth		Yes	□ No						sought or received		
	i. Rheumatic fever or he		Yes	No						nmune Deficiency		
	k. Chest pain or circulat	tory disorders	Yes	☐ No						complex (ARC), or AIDS diseases, including	☐ Yes	∐ No
	I. Reproductive organ d		Yes	☐ No						or Kaposi's Sarcoma?		
	m. Substance or alcoho	ol abuse	Yes	☐ No			u ever tes			<u>'</u>	Yes	No
	n. Cancer or tumors		Yes	☐ No	-		, are you		•			
	o. Ulcer		Yes	□ No			, are you ected date				☐ Yes	☐ No
	p. Colitis		Yes	☐ No			o Usage					
2 1101/6	q. Diabetes	l neogadura ar baan	res	□ NO	10. 1				malıa a	inorattani		
	e you <b>ever</b> had a surgica I to have surgery which l		Yes	□No		a. Do	If Yes,	entry s		igarettes?	☐ Yes	☐ No
at this t		las not been completed							per d	•		
3 Have	you consulted or been	attended by a physician			1		-			garettes?	☐ Yes	□No
	titioner and/or taken pres		Yes	□No			Yes, date					
within t	ne past five years?	. , ,				c. Ha		sed an	y tobac	co products in the past 10	☐ Yes	☐ No
	٥.		""			,		. ,				
	-	olete details below for all	"Yes" ans	swers to a					-	names and phone numbers i	or all pn	I
Question No.	Disease, injury or Medical	Treatment / Medication /					nt Dates	<u> </u>	alized?	Attending Physician	ımbar)	Degree of
INO.	Condition	alcohol abuse, provide da	te or last cons	sumption)	F	rom	То	Yes	No	(doctor name and telephone nu	imber)	Recovery
Į,	Section B											
Ľ												
	Employee Agr	eement & Sign	ature									

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term-Life coverage offered by PEHP: (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

	-	
EMPLOYEE SIGNATURE	,	DATE

State of Utah

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004 Customer Service: 801-366-7555 / Toll Free 800-765-7347

Group Term Life Spouse/Dependent Child Health Statement

E	imployee Name:				Socia	Secur	ity Nu	mber:			
	Section A										
<u> </u>	Complete applying f		or one for	each dep	endent (mak				ecessary). This information rriage date. This is also re		
Name	(Last, First, M.I.):			Date of	Birth:		H	Height (F	ft., In.): W	/eight:	
Relatio	onship To Employee:			-	Оссі	pation:					
	a. High blood pressure	s, been diagnosed with, o	Yes	☐ No	deformities,	or physi	cal or n	nental in	any known physical npairments, disorders or ill	☐ Yes	□ No
	<ul><li>b. Seizures or convulsion</li><li>c. Mental or nervous convulsion</li></ul>		Yes Yes	<del>                                      </del>	health not n				? Ith insurance coverage, or		
	<ul><li>d. Lung or respiratory d</li><li>e. Digestive or rectal dis</li></ul>		Yes Yes	☐ No	received an	increase	ed prem	nium rati	ng for health reasons?	☐ Yes	□ No
	f. Blood or blood vessel g. Urinary tract disorder	disorders 's	Yes Yes Yes	□ NO	6. Have you study, blood the past three	l study, k	ody sc	ectrocar an or dia	diogram, x-ray, laboratory agnostic procedure within	☐ Yes	□ No
	h. Skeletal, spine, joint or muscle disorders  I. Thyroid, breast or other glandular disorders j. Rheumatic fever or heart disorders k. Chest pain or circulatory disorders I. Reproductive organ disorders			No No No	treatment o Syndrome ( related diag	r advice AIDS), A nosis or	for Acqı IDS Re opportu	uired Im lated Co unistic di	ought or received mune Deficiency omplex (ARC), or AIDS seases, including r Kaposi's Sarcoma?	☐ Yes	. □ No
	m. Substance or alcohon. Cancer or tumors	ol abuse	Yes Yes	☐ No No	8. Have you					☐ Yes	. □ N
	o. Ulcer p. Colitis		Yes Yes	No No	9. If female, If yes, expe	cted date	e of deli			☐ Yes	□ No
	q. Diabetes  Have you <b>ever</b> had a surgical procedure or been vised to have surgery which has not been completed this time?		☐ Yes	□ No	a. Do you currently smoke cigarettes?  If Yes,per day					☐ Yes	□ No
or pract	you consulted or been itioner and/or taken pres ne past five years?		☐ Yes	☐ No	b. Have you ever smoked cigarettes?  If Yes, date last smoked?  c. Have you used any tobacco products in the past 10 years?					☐ Yes	+=-
	Give com	olete details below for all	"Yes" ans	wers to ab	oove questio	ns. Prov	ide con	nplete na	ames and phone numbers	for all ph	ysicians.
Question No.	Disease, injury or Medical Condition	Treatment / Medication /			Treatment Date		Hospit Yes	alized?	Attending Physician (doctor name and telephone name)	umber)	Degree o
					TIOIII	10	165	NO	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
	Section B										
Ľ	Employee Agi										

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable; By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

EMPLOYEE SIGNATURE	DATE	SPOUSE SIGNATURE (Required if applying for Spouse Term-Life Coverage)	DATE
			1

State of Utah

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004 Customer Service: 801-366-7555 / Toll Free 800-765-7347

Group Term Life Dependent Child Health Statement

E	Employee Name:							Soci	al Secu	rity Nu	ımber:			
	Section A													
L	Dependent Ch	nild Health State	eme	nt										
	Complete		Deper	nden								ired for each dependent if a	applying	for
Name	(Last, First, M.I.):				_ [	)ate c	f Birth	: _			Height (F	Ft., In.): V	Veight:	
Relati	onship To Employee:							Occ	cupation:					
1. Have	you <b>ever</b> had symptom	s, been diagnosed with,	or bee	n tre	ate	ed for	4. H	ave yo	ou had or	current	ly have a	any known physical		
	a. High blood pressure		-=-	es		No						npairments, disorders or ill	□ Ye	1 🔲 l
	b. Seizures or convulsion		-=-	es	Ļ	No			mentione	· ·				
	d. Lung or respiratory d		=	es	누	No No						or health insurance	☐ Ye	s
	e. Digestive or rectal di		-=-	es	十	No	_					I premium rating for health	-	$\perp$
	f. Blood or blood vesse		=	es	F	No						am, x-ray, laboratory	☐ Ye	.  _ ,
	g. Urinary tract disorder	rs	Y	es		No			nree years		an or di	agnostic procedure within	re	1 ∐ l
	h. Skeletal, spine, joint		Y	es		No	<u> </u>				VA VALLE	ought or received		
	I. Thyroid, breast or oth			es	Ļ	No						mune Deficiency		
	j. Rheumatic fever or he		-=-	es	느	No	Synd	drome	(AIDS),	AIDS R	elated C	omplex (ARC), or AIDS	☐ Ye	1 🔲 l
	k. Chest pain or circula  I. Reproductive organ of	· ·	=	es	늗	No No						iseases, including		
	m. Substance or alcoho		=	es	H	No	-		<u></u>			r Kaposi's Sarcoma?		
	n. Cancer or tumors		-=-	es	Ť	No	-		ou ever te			re?	Ye	1 🔲 a
	o. Ulcer		Y	es		No			e, are you				☐ Ye	ı
	p. Colitis		+=-	es		No	Ļ		ected dat		ivery: _		-	
	q. Diabetes		Y	es	L	No	10.		cco Usage					
	you <b>ever</b> had a surgica				_	1		a. D	•	•	smoke ci	garettes?	☐ Ye	s
advised	d to have surgery which	nas not been completed	□ Y	es	L	No			If Yes,		per da	ay		٠ ا ا
		- 0 d - d b b 2-2					-	b. F	lave you	ever sn	noked cig	garettes?		s
	e you consulted or been titioner and/or taken pres				_	1		lf	Yes, dat	e last s	moked?	·	_   ∐ Ye -	s
	he past five years?	scription medication(s)		es	L	No		c. F	•	used ar	y tobaco	co products in the past 10	☐ Ye	s 🔲 s
	Give com	plete details below for all	"Yes"	ans	wei	rs to a	bove	quest	ions. Prov	ride coi	nplete n	ames and phone numbers	for all pl	nysician
Question	Disease, injury or	Treatment / Medication /	Dosag	e (for	sub	stance	, 7	reatm	ent Dates	Hospi	talized?	Attending Physician		Degree
No.	Medical Condition	alcohol abuse, provide da						From	То	Yes	No	(doctor name and telephone no		Recove
										-				
Ī	0 (' D													
	Section B													
	Employee Ag	reement & Sign	atur	e										
		_			1 , , , ,	dere	and a	ny ma	tarially in	correct	incompl	ete or misstated facts may	recult in	the
												ete of misstated facts may fits payable. By signing bei		
												cally related practitioners of		
	insurance comp	panies, the Medical Inforr	nation	Bur	eau	ı, or c	ther o	rganiz	zations, in	stitutio	ns or per	rsons any information nece	ssary to	process
												any previous Employee, S s in the PEHP Group Term		

EMPLOYEE SIGNATURE DATE

State of Utah

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004 Customer Service: 801-366-7555 / Toll Free 800-765-7347

Group Term Life
Dependent Child Health Statement

I	Employee Name: _					_	5	Socia	l Secur	ity Nu	ımber:			
Ī	Section A													
L	Dependent Cl	hild Health State	emen	t										
	•				Chil	ld T	erm Lif	e cov	erage. Oi	ne form	is requ	ired for each dependent if a	applying	for
	Depende	ent coverage after 60 day	s from I	ire d	date	, bii	th date	e, mar	riage dat	e, or a	doption/p	placement.		
Name	e (Last, First, M.I.):				Dat	te o	f Birth:			I	Height (F	Ft., In.): V	/eight:	
Relati	ionship To Employee:							Occi	upation:					
1. Hav	re you <b>ever</b> had symptom	s, been diagnosed with,	or been	trea	ted	for:	4. Ha	ve yo	u had or	current	y have a	any known physical		
	a. High blood pressure		☐ Ye		_	10						npairments, disorders or ill	☐ Yes	i 🗌 No
	b. Seizures or convulsion		Ye		=-	10			nentione					
	c. Mental or nervous co		Ye Ye			10 10						or health insurance	☐ Yes	s 🔲 No
	e. Digestive or rectal di		Ye		='-	10						I premium rating for health		
	f. Blood or blood vesse		☐ Ye		=-	10						am, x-ray, laboratory agnostic procedure within	☐ Yes	s │ <sub>□ No</sub>
	g. Urinary tract disorde		☐ Ye	s [	_ N	10	,	,	ee vears	,	an or un	agnostic procedure within		
	h. Skeletal, spine, joint		☐ Ye		=-	10	7. In t	he pa	st ten ve	ars, ha	ve vou s	ought or received		
	I. Thyroid, breast or oth i. Rheumatic fever or he		Ye Ye		_	10	treatn	nent c	r advice	for Acq	uired Im	mune Deficiency		
	k. Chest pain or circula		Ye		='-	10 10						omplex (ARC), or AIDS	☐ Yes	i 🗌 No
	I. Reproductive organ of		Ye		=-	10 10						iseases, including r Kaposi's Sarcoma?		
	m. Substance or alcoho		Ye	s [	N	10			u ever tes			· ·	Yes	. □ No
	n. Cancer or tumors		Ye			10			, are you		•	<u> </u>		140
	o. Ulcer p. Colitis		Ye Ye		_	10 10			cted date				☐ Yes	i 🗌 No
	g. Diabetes		Ye			10			co Usage				-	
2. Hav	re you <b>ever</b> had a surgica	l procedure or been		, [		••	1.0.				moke ci	garettes?		
	d to have surgery which		☐ Ye	s [	_ N	Ю		u. D.	If Yes,	-	per da	~	☐ Yes	i 🗌 No
at this	time?							ЬЦ		_		<u>,                                      </u>		
	e you consulted or been								res, dat		-	garettes?	☐ Yes	i 🗌 No
	ctitioner and/or taken preather past five years?	scription medication(s)	☐ Ye	s [	_ N	Ю						co products in the past 10		<del> </del>
vvitiiiii	the past live years:							year	-		,		☐ Yes	S     No
	Give com	plete details below for all	"Yes" a	nsw	ers	to a	bove q	uestic	ns. Prov	ide cor	nplete n	ames and phone numbers	for all ph	ysicians.
Question		Treatment / Medication /					Tr	eatme	nt Dates	Hospit	alized?	Attending Physician		Degree of
No.	Medical Condition	alcohol abuse, provide da	te of last o	onsur	nptio	n)	F	rom	То	Yes	No	(doctor name and telephone nu	ımber)	Recovery
		<u>I</u>											l	
	Section B													
L														
	<b>Employee</b> Ag	reement & Sign	ature	•										
												ete or misstated facts may		
												fits payable. By signing bel		
												cally related practitioners of sons any information nece		
												any previous Employee, S		
	Dependent Chi	ldren Term Life coverage	offered	by I	PEH	IP; (	(4) agre	ee to t	he terms	and co	onditions	s in the PEHP Group Term	Life Mas	ter Policy

EMPLOYEE SIGNATURE DATE